

08270

CERTIFICATE OF DEATH

08257

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN lb 35 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne's Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown, d. STREET ADDRESS 341 High Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Eleanor Mae Allen				4. DATE OF DEATH Month Day Year 6 20 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1920 12/31/1919/	
9. AGE (In years last birthday) 46 46 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME George Cornelius Barr				14. MOTHER'S MAIDEN NAME Ada MNM Northcraft			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 232-26-1404		17. INFORMANT Address Hospital Records Chestertown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral of liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/16 , 1967 , to 6/20 , 1967 , that (I) (we) last saw the deceased alive on 6/20 , 1967 , and that death occurred at 10:10 P.M. , from causes and on the date stated above.							
22a. SIGNATURE A. C. Dick M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-21-67	
22c. PHYSICIAN'S NAME (Type) Dr. A. C. Dick				22d. ADDRESS Chestertown, Maryland 21620			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/23/1967		23c. NAME OF CEMETERY OR CREMATORY Johnstown Cem.		23d. LOCATION (City or Town) (County) (State) Earleville Cecil Co. Md.	
24. FUNERAL DIRECTOR J. Willis Wells				ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE JUN 26 1967	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2 From Birth Cert

CERTIFICATE OF DEATH

08271

08258

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER TOWN</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Haddon Heights</u> <u>673</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kent End QUEEN Anne's Hosp</u>		d. STREET ADDRESS <u>White Horse Pike</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u> First Middle Last <u>DERATO</u>		4. DATE OF DEATH <u>June 27</u> 19 <u>67</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-26-67</u>
9. AGE (In years last birthday) Yrs. <u>21</u> Months <u>20</u> Days <u>20</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Kent Co, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>FRANK James DERATO</u>	
14. MOTHER'S MAIDEN NAME <u>ROSE MARY NMN De MATINI</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MOTHER</u> Address <u>White Horse Pike</u> <u>Haddon Hts. N. J.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>6-26</u> , 19 <u>67</u> , to <u>6-27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-26</u> , 19 <u>67</u> , and that death occurred at <u>3:35A</u> M, from causes and on the date stated above.	
22a. SIGNATURE <u>A.C. Dick</u>		22b. DATE SIGNED <u>6-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>		22d. ADDRESS <u>Chestertown, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>6/27/67</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Kent + Queen Anne's Hosp</u>		23d. LOCATION (City or Town) (County) (State) <u>Chestertown Kent Md.</u>	
24. FUNERAL DIRECTOR <u>R. W. Marin Administrator</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JUN 30 1967</u>	

10880

STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
08272					CERTIFICATE OF DEATH					08259	
1. PLACE OF DEATH a. COUNTY Kent MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Kent.						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesterville.					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesterville.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LEONARD			First A. Middle DURHAM. Last		4. DATE OF DEATH June, 22, 19 67		Month June, Day 22, Year 19 67				
5. SEX Male		6. COLOR OR RACE White.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March, 22, 1887		9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming.		11. BIRTHPLACE (County & State, or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Benjamin Durham					14. MOTHER'S MAIDEN NAME Emma Feffer.						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 213-24-1275		17. INFORMANT Daughter			Address Mrs. Pauline Skinner, Crumpton, Md. 21828			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Dilatation H221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) General Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Frailty & General Asthenia										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) NP	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 11			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from July 1950 to July 22, 1947 , that (I) (we) last saw the deceased alive on July 22, 1947 , and that death occurred at 7 P.M. from the causes and on the date stated above.											
22a. SIGNATURE C.H. Metcalfe										22b. DATE SIGNED 6/24/67	
22c. PHYSICIAN'S NAME (Type) C.H. Metcalfe, M.D.					22d. ADDRESS Sudlersville, Md. 21668						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF June, 25, 1967		23c. NAME OF CEMETERY OR CREMATORY Crumpton Cemetery.			23d. LOCATION (City, town or county) (State) Crumpton, Q.A.Co; Md.			
24. FUNERAL DIRECTOR Edward Fellows & Son.					ADDRESS Millington, Md. 21651			25a. REC'D BY REGISTRAR JUN 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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82-11, 2nd, Sullivan St.

08273

CERTIFICATE OF DEATH

08260

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN lb <u>172</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Kent & Queen Anne Hospital</u>		d. STREET ADDRESS <u>Rt. #1</u>	
NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Bernard</u> Last <u>Gorton Jr.</u>		4. DATE OF DEATH Month <u>6</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-5-12</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rhode Island Mass.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Rhode Island Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Frank Bernard Gorton Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Harriett NMN Hannond</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>039-09-0120</u>	
17. INFORMANT <u>Mrs. Alice Gorton, Sudlersville, Md. 21668</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial decompensation</u> DUE TO <u>5420</u> (b) <u>Cor pulmonale</u> DUE TO <u>8 yrs</u> (c) <u>chronic bronchitis & emphysema</u> DUE TO <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-7</u> , 19 <u>67</u> , to <u>6-10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-9</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Harry P. Ross</u>		22b. DATE SIGNED <u>6-10-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Harry P. Ross</u>		22d. ADDRESS <u>Chestertown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 13, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sudlersville Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Sudlersville, Q.A.Co; Md.</u>	
24. FUNERAL DIRECTOR <u>Edward Fellows</u>		25. REC'D BY REGISTRAR <u>JUN 14 1967</u>	
25a. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE	

1992

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08274

CERTIFICATE OF DEATH

08261

1. PLACE OF DEATH a. COUNTY <u>Kent County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester town</u>		c. LENGTH OF STAY IN lb <u>1mo. & 1 day</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Golts, Md</u>		d. STREET ADDRESS <u>Route #1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kent & Queen Anne's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Bradford</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-83</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Kent Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Anthony ? Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Laura ? Wooters Wooters</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-36-0378</u>	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>31 days</u> <u>Second phase</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-20</u> , 19 <u>67</u> , to <u>6-3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-3</u> , 19 <u>67</u> , and that death occurred at <u>10:27</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>A.C. Bick</u>		22b. DATE SIGNED <u>6-5-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.C. Bick</u>		22d. ADDRESS <u>Chester town, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June, 6, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Galena Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Galena, Kent Co; Md.</u>	
24. FUNERAL DIRECTOR <u>Edward F. Haller</u>		25a. REC'D BY REGISTRAR <u>JUN 7 1967</u>	
ADDRESS <u>Wilmington Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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OFFICE OF THE

08374

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
08275					08263					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY Kent					a. STATE Maryland b. COUNTY Kent					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Rock Hall					Rock Hall R.D.#2					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS					
Hinchingham Farm					Hinchingham Farm					
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
Emma B. Mackie					June 16, 1967					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		
female		white		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		7/8/1876		90 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Housewife						West Chester, Pa.		USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Thomas O'Connell					Levinia Scott					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT			Address		
(If yes give war or dates of service)					Mr. Frank H. Mackie, Jr. Rd., Wilm. (7)			1103 DuPont		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema										
4221										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								(b) Cardio Vascular		
								(c) Arterio Sclerosis & Anemia		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
Hour a.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						
21. I certify that (I) (this hospital) attended the deceased from Aug 18, 1966, to June 16, 1967, that (I) (we) last saw the deceased alive on June 16, 1967, and that death occurred at 1 A.M. from the causes and on the date stated above.										
22a. SIGNATURE								22b. DATE SIGNED		
Norbert C. Nitsch								6/16/67		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS					
Norbert C. Nitsch					Rock Hall, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
Burial			6/19/67		Sharps Cemetery			Fairhill, Maryland		
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Albert J. McCreary, Jr.					2700 Wash. St. Del.		JUN 23 1967		Charles Judge	

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Rock Hill, N.C.

Rock Hill, N.C.

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1103 1700

Mr. Frank H. Macke, Jr., 1103 1700



Rock Hill, N.C.

Rock Hill, N.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
08276 CERTIFICATE OF DEATH 08264										
1. PLACE OF DEATH a. COUNTY Kent MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Kent					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond			c. LENGTH OF STAY IN 1b 15 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond 141					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ---					d. STREET ADDRESS ---			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Clarence R. Nicholson			First Middle Last		4. DATE OF DEATH June 6, 19 67		Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Dec. 21 1889		9. AGE (In years last birthday) 77 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (County & State, or foreign country) Kent Co., Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John B. Nicholson					14. MOTHER'S MAIDEN NAME Margaret S. Gardner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. W.W. I 216-56-1474		17. INFORMANT Oliver C. Nicholson			Address Still Pond, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH several years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11/29 , 19 66 , to 6/6 , 19 67 , that (I) (we) last saw the deceased alive on 6/6/67 19____, and that death occurred at 7:30 PM , from the causes and on the date stated above.										
22a. SIGNATURE Robert W. Farr					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 6/8/67		
22c. PHYSICIAN'S NAME (Type) Robert W. Farr M.D.					22d. ADDRESS Chestertown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 6-10-67		23c. NAME OF CEMETERY OR CREMATORY Still Pond Cemty.			23d. LOCATION (City, town or county) (State) Still Pond, Kent Md.		
24. FUNERAL DIRECTOR Victor N. Kennedy					ADDRESS Still Pond, Md.		25a. REC'D BY REGISTRAR JUN 9 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
08277 Item #9 Film #G309 6/20/67 PG										
08265										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Kent MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rock Hall			c. LENGTH OF STAY IN 1b 4 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rock Hall					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Chesapeake St.					d. STREET ADDRESS Chesapeake St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Harry C. Post					4. DATE OF DEATH Month Day Year June 14, 1967 19					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 22, 1894		9. AGE (in years last birthday) 72 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Boilmaker			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME don't know					14. MOTHER'S MAIDEN NAME don't know					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes WW 1			16. SOCIAL SECURITY NO. 184 10 6477		17. INFORMANT Margaret Post			Address: Chesapeake St. Rock Hall, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-vascular accident</i> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> (c) <i>old age</i>								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>10-15-1964</i> to <i>6-10-1967</i> , that (I) (we) last saw the deceased alive on <i>6-10-1967</i> , and that death occurred at <i>3A</i> M, from the causes and on the date stated above.										
22a. SIGNATURE <i>Rudolf Eglitis</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 6/14/67		
22c. PHYSICIAN'S NAME (Type) Rudolf Eglitis					22d. ADDRESS Rock Hall, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 6/15/67		23c. NAME OF CEMETERY OR CREMATORY Silverbrook Crematory			23d. LOCATION (City, town or county) (State) Wilmington, Del.			
24. FUNERAL DIRECTOR <i>J. Willis Wells</i>					ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE JUN 16 1967		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

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08277

British-American
Refineries
Inc.

10-17-47

24

10-17-47

Pratt & Whitney

Wells

Chesapeake

10-17-47

08278

CERTIFICATE OF DEATH

08266

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 20 hrs.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Batterton		d. STREET ADDRESS ---		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nancy Maxwell Price		4. DATE OF DEATH Month 6 Day 17 Year 1967		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. B. DATE OF BIRTH Jan. 25, 1885		9. AGE (In years last birthday) 82		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (County & State, or foreign country) Kent Co., Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Henry Price		14. MOTHER'S MAIDEN NAME Mary Catherine Baker		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 217-36-0050	
17. INFORMANT Mrs. Alexander Schreiber		18. ADDRESS Chesapeake City, Md.		19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO (b) Arteriosclerosis DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH 17 hours		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Worton		20g. (County) Kent		20h. (State) Md.		21. I certify that (I) (this hospital) attended the deceased from 6-16 , 19 67 to 6-17 , 19 67 that (I) (we) last saw the deceased alive on 6-16 , 19 67 , and that death occurred at 4:32 M, from causes and on the date stated above.		22a. SIGNATURE Dr. Dick	
22b. DATE SIGNED 6-17-67		22c. PHYSICIAN'S NAME (Type) Dr. Dick		22d. ADDRESS Chestertown, Md.		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. REC'D BY REGISTRAR JUN 20 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-19-67		23c. NAME OF CEMETERY OR CREMATORY I. U. Cemetery		23d. LOCATION (City or Town) Worton, Kent Md.		23e. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR Victor M. Kennedy		ADDRESS Still Pond, Md.		25a. REC'D BY REGISTRAR JUN 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
08279 CERTIFICATE OF DEATH 08267									
1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Massey Rural c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Md. f. COUNTY Kent. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Massey, d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First S. Middle ALDRICH Last PRICE.					4. DATE OF DEATH Month June Day 11, Year 19 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February, 8, 1886		9. AGE (In years last birthday) 81 yrs. IF UNDER 1 YEAR: Months 14 Days 1 IF UNDER 24 HRS.: Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (County & State, or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edgar Thomas Price.					14. MOTHER'S MAIDEN NAME Anna Bennett.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.			16. SOCIAL SECURITY NO. No.		17. INFORMANT Mrs. Ola Price.			Address Massey, Md. 21650	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 331X DUE TO (b) Cerebral hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH 3 days 2 months 1 year?	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 9.16 , 19 66 , to 6.11 , 19 67 , that (I) (we) last saw the deceased alive on 6.10 , 19 67 , and that death occurred at 12 A -M, from the causes and on the date stated above.									
22a. SIGNATURE Geza Koralewski					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 6.12.67	
22c. PHYSICIAN'S NAME (Type) Geza Koralewski, M.D.					22d. ADDRESS Millington, Md. 21651				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June, 15, 1967		23c. NAME OF CEMETERY OR CREMATORY Hickory Grove Cemetery.			23d. LOCATION (City, town or county) (State) Port Penn, Del.		
24. FUNERAL DIRECTOR Edward Fellows,					ADDRESS Millington, Md. 21651		25a. REC'D BY REGISTRAR JUN 14 1967 DATE		25b. REGISTRAR'S SIGNATURE James J. J...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08280

CERTIFICATE OF DEATH

08268

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne's Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond, d. STREET ADDRESS 141 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Myra Katherine Roseberry		4. DATE OF DEATH Month June Day 30 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH -02-28-1878
9. AGE (In years last birthday) 89		10. IF UNDER 1 YEAR Months 14 Days 14 Hours 14 Min. 14	11. IF UNDER 24 HRS. Months 14 Days 14 Hours 14 Min. 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM OWNER		10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE	
11. BIRTHPLACE (County & State, or foreign country) Maryland - Kent Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hamilton Crew		14. MOTHER'S MAIDEN NAME Sarah Harris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-36-7213	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 days (c) 2 days		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Cecum		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/25 , 19 67 , to 6/30 , 19 67 , that (I) (we) last saw the deceased alive on 6-30 , 19 67 , and that death occurred at 3:05AM , from causes and on the date stated above.			
22a. SIGNATURE Dr. Arthur T. Keefe		22b. DATE SIGNED 6-30-67	
22c. PHYSICIAN'S NAME (Type) Dr. Arthur T. Keefe		22d. ADDRESS Chestertown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-2-67	
23c. NAME OF CEMETERY OR CREMATORY STILL POND CEMTY		23d. LOCATION (City or Town) (County) (State) STILL POND KENT MD.	
24. FUNERAL DIRECTOR VICTOR N. KENNEDY		25a. REC'D BY REGISTRAR STILL POND, MD.	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		25c. DATE JUL 3 1967	

85800

4853C

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.)

VR A15 (4)
2DM 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
08281											
08269											
1. PLACE OF DEATH a. COUNTY <u>Kent</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kent + Queen Anne Hosp</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> d. STREET ADDRESS <u>835 W. High St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Addie</u> Middle <u>Francis</u> Last <u>Townsend</u>						4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 8 1891</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u> Hours <u>13</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>George Washington Trithman</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Money</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>318-34-8434</u>		17. INFORMANT <u>Mr. Clifton Townsend</u>		Address <u>835 W. High St. Chestertown Md</u>			
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary failure (c.p.s.)</u> 443X DUE TO (b) <u>Arterio-sclerotic hyper-tension heart disease</u> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
INTERVAL BETWEEN ONSET AND DEATH <u>Over 2 years</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4-24</u> , 19 <u>65</u> , to <u>6-13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-13</u> , 19 <u>67</u> , and that death occurred at <u>12</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>A.C. Dick</u>						22b. DATE SIGNED <u>6-13-67</u>		22c. PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>			
22d. ADDRESS <u>Chestertown, Md</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <u>June 15, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chesler Am.</u>		23d. LOCATION (City, town or county) (State) <u>Chestertown Kent Co. Md</u>			
24. FUNERAL DIRECTOR <u>Wm. C. Wellham</u>						ADDRESS <u>Chestertown Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JUN 16 1967</u>											

13260

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08282

08270

1. PLACE OF DEATH a. COUNTY KENT b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MILLINGTON - RURAL c. LENGTH OF STAY IN 1b 3 weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNES c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GRASONVILLE - 17 d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First OSCAR Middle _____ Last TRICE				4. DATE OF DEATH 6-11-67 19 67			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-1-86 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Solomon Trice				14. MOTHER'S MAIDEN NAME No Record			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Edgar Trice, Queen Anne, Md. Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 113X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. KNOWN HYPERTENSIVE CARDIOVASCULAR DISEASE (b) BRIND, CACHECTIC, DEHYDRATED ETC ON EXAM DR. LIBBY 7/1/67 (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Adm Address (Street, city, town, or county) KENT							
ACTUAL SIGNATURE O. S. GULBRANDSEN, M.D.		22. DATE SIGNED 6-11-67					
EXAMINER'S NAME (Type) O. S. GULBRANDSEN, M.D.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 6-15-67		23c. NAME OF CEMETERY OR CREMATORY Union		23d. LOCATION (City, town or county) (State) Goldboro, Md.	
24. FUNERAL DIRECTOR J. E. Boulain ADDRESS Greensboro, Md.				25a. REC'D BY REGISTRAR JUN 14 1967 OATE		25b. REGISTRAR'S SIGNATURE Charles Judge	

03282

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03282

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some legible fragments include:]

NAME: ...
AGE: ...
SEX: ...
DATE OF BIRTH: ...
PLACE OF BIRTH: ...
RESIDENCE: ...
CAUSE OF DEATH: ...
DATE OF DEATH: ...
SIGNATURE: ...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
08283					Reg. Dist. 08271					
1. PLACE OF DEATH a. COUNTY Kent MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedysville			c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Betterton					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ---					d. STREET ADDRESS ---			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Joseph Middle Walter Last Webb					4. DATE OF DEATH Month June Day 13 , Year 1967					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 18, 1949		9. AGE (In years last birthday) 17 yrs.		
						IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY school		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph J. Webb					14. MOTHER'S MAIDEN NAME Mildred Alene Woodall					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Joseph J. Webb		Address Betterton, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epilepsy 3533 DUE TO Has had epilepsy for many years and has been under treatment at the Kent County Health Dept. Seizure clinic. Felt badly all day 6/13/67. Had been having increased seizures for several weeks despite changes & increases of medication. Had 2 seizures in rapid succession P.M. of 6/13/67. Died following the last, at about 8:20 P.M. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6/15/67								
EXAMINER'S NAME (Type) Robert W. Farr, M. D.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-16-67		22c. NAME OF CEMETERY OR CREMATORY Still Pond Cemty.		22d. LOCATION (City, town, or county) Still Pond Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy					ADDRESS Still Pond, Md.		24a. REC'D BY REGISTRAR DATE JUN 16 1967		24b. REGISTRAR'S SIGNATURE John J. Judge	

STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1

8233

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

1